Elevance / Anthem Medicare Advantage

Date: _____

Indicates required field

Check Eligibility Please enter the member information to check PERS service eligibility.

*Member ID: _____

Member Details

*First name:_____ *Last name:_____ *Date of birth:_____

*Medicare ID:_____ *Email:_____

*Gender:_____ *Language:_____ *Effective date:_____

*Phone number (please enter at least one contact for the member):

Mobile: _____ Home: _____

Service Address Information

*Street address: _____ Apt/Suite/Other:_____

*City: _____ *State: _____ *Zip code:_____

Member Medical Information

Diagnoses and Conditions

☐ Check here if no conditions

_____

_____

Allergies

☐ Check here if no allergies

_____

_____

Primary Care Physician

Physician full name: _____ Phone: _____

Elevance Case Manager Details

If the Elevance member has an Elevance Manager, please add their details.

_____

_____

Emergency Contacts

*Emergency contacts/personal responders will be contacted following the response protocol.

Emergency contact #1

*First name: _____   *Last name: _____

*Phone: _____   *Relationship: _____

*Does this contact live with the member?   ☐   ☐ Yes   No

*Does this contact have a key to the member's home?   ☐ Yes ☐ No

Emergency contact #2

First name: _____   Last name: _____

Phone: _____   Relationship: _____

Does this contact live with the member?   ☐ Yes ☐ No

Does this contact have a key to the member's home?   ☐ Yes ☐ No

Emergency Information

Living situation: _____   Pets: _____

Is there an access code at this address?   ☐ Yes ☐ No

Access Instructions (lockbox code, key location, or other important info when accessing member's home):

_____

_____

Service Information

☐ Mobile PERS device

☐ In-home PERS device

Additional information

Please include any additional comments relevant to this member or their referral.

_____

_____